UCI

SF 4400-DIS (4-2005)
Supersedes (6-2002) issue

Sandia National Laboratories

Medical Insurance Dependent Disenrollment Form

A) Medical Plan Information

Please select the plan that you are currently enrolled in.

☐ Top ☐ Intermediate ☐ Basic ☐ CIGNA

B) Primary member information:

I am a(n): *(check one)* ☐ Employee or Student employee ☐ Retiree ☐ Surviving Spouse ☐ COBRA participant

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____ Social Security Number _____

Street Address _____ City, State *(Please abbreviate)* _____ Zip Code _____

Home Phone _____ Work Phone _____

Union Affiliation *(check one)* ☐ None ☐ OPEIU ☐ MTC ☐ SPA

C) Disenrollment Information:

Please list below each dependent to be disenrolled.

Last Name, First Name	Date of Birth	Reason for disenrollment: (mid-year election change event)	Date of Change	**For Benefits Use Only: Disenrollment Date**

D) Sign below to authorize the disenrollment of the above dependent(s) from your medical insurance:

Employee Signature _____ Date _____

E) If applicable, remove the dependent(s) listed above from your other insurances and update your beneficiaries.

Note: This form must be received by the Benefits Customer Service Center within 31 days of the mid-year election change event if your premiums are deducted on a pre-tax basis.

Fax this form to 505-844-7535 or mail to:
Sandia National Laboratories
Attn: Benefits Customer Service
PO Box 5800 MS 1022
Albuquerque, NM 87185-1022

For Benefits Use Only:	Date change entered: PS: _____ Rx: _____
Benefits Employee Signature	

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